Dialogue Themes and Findings

As the dialogue began, participants shared in-depth, personal experiences in consumer-faith interactions that have promoted or hindered recovery from mental illnesses. By telling personal stories, participants understood better the context from which they each spoke, and they learned that they had shared many of the same types of experiences. The stories helped increase empathy and reduce perceived differences among the participants. These histories lay the foundation for further discussion dialogues to build partnerships.

Some participants spoke about the positive impact of spirituality and either personal or organized religion on their recovery and coping . . .

"I believe that a relationship with God and spirituality are the most important supports to help us recover." (Consumer)

"The one thing that kept me from going off the deep end after three suicide attempts was that God had other plans for me." (Consumer)

"My spirituality is internal. After having been locked up in seclusion for 45 days, I discovered I had found spirit." (Consumer)

Others revealed the pain they suffered due to some faith communities' lack of knowledge of how to help them . . .

"Mental illness is a 'no casserole' disease. When you have other illnesses, congregations reach out— not always with mental illness." (Family member)

Some told stories about having been turned away by faith communities and their leaders . . .

"I have worked with religious people for eons, and I have been turned away many times. Once in a while, I'd come across a religious group that would tolerate me for a tad, but not for long." (Consumer)

Participants who work as advocates for persons with mental health problems described how both positive and negative experiences affected their work . . .

"I finished seminary, but I realized I would not flourish where people would be suspicious of my abilities and performance. Also I was recognizing that people were not speaking up about mental illness, and people had no one to advocate for them. I decided to pursue advocacy rather than ordination." (Consumer)

Leaders of faith communities discussed encountering and/or fashioning welcoming environments for persons with mental illnesses . . .

"Some congregations have hired therapists for families and members who have mental illnesses. The services provided are free to those families." (Consumer)

"It took me twenty years until I found a church that wanted to do a ministry to people with severe mental illnesses. We wanted consumers integrated into all parts of the church. The vision just exploded. We have maybe a hundred consumers in all." (Clergy/consumer)

Some participants described their work with community-based support programs that include a focus on spirituality. . .

"We made major changes in the local mental health system. We invited ministers, consumers, and staff. We wanted to look at spirituality in new ways to be helpful to people we serve. We started training mental health staff and religious professionals to run therapy groups as part of the services." (Mental health professional)

"I am not a mental health consumer, but I have interacted with many consumers. It is my charge and calling to enable our faith's resources to reach out into the community in partnership with government. But the armies of compassion are not engaged. Our churches tend to build walls." (Faith community worker)

Factors That Promote Recovery

Participants identified factors that contribute to recovery within faith and community organization settings:

A sense of community

- Faith communities can offer a safe, comfortable, nonjudgmental environment to mental health consumers.
- Personal outreach, the development of a social network, and the community's gifts of "being present," of listening, and of friendship contribute to a validating environment. An organization's spirit of hospitality, expressed by both clergy and congregants, can serve as a welcoming beacon.
- Persons with mental illnesses have opportunities for self-disclosure—to tell their personal stories.
- People have opportunities to forge connections in a spirit of trust and acceptance.

- Consumers' participation in and contributions to the faith community are valued.
- A consumer can begin a relationship with a faith community simply by telling his or her story to a member of the clergy or a lay leader and explaining how faith has been important for coping with a mental illness personally or in the family.

"Consumers across the country consider their top needs to be housing, jobs, and social supports. Faith and community organizations play such a crucial role in these areas." (Consumer)

Rituals and other spiritual practices. Faith-based rituals and other spiritual practices can foster recovery among persons with mental illnesses. Rituals and other practices can include

- Prayer (personal and congregational, formal and informal)
- Personal testimony
- Meditation

The forms may differ, but spiritual practices are an important aspect and value of a faith community's connection with mental health consumers. Faith communities can help people achieve solace and foster a greater sense of belonging.

"Talking about mental illness from the pulpit is healing and opens doors." (Consumer)

Understanding mental illnesses and psychiatric disabilities. Faith communities that understand mental illnesses and psychiatric disabilities are better able to meet the needs of mental health consumers. The following concepts are important for faith communities both to understand and to act on:

- People can recover from mental illnesses.
- Each consumer has unique needs that require individual supports, rather than "cookie-cutter" approaches.
- Discrimination and stigma impede recovery. Faith communities that help overcome fears, stigma, and discrimination regarding mental illness are better able to serve persons with mental illnesses.
- "Connectedness" to family, faith, peers, the faith community—or anyone who listens and supports during a time of need—is important to persons with mental illnesses. Empathy and listening help build relationships.

- A holistic mind/body/spirit approach that acknowledges a person's strengths (as well as weaknesses) places mental illness and psychiatric disability in the context of the whole person.
- The cyclical nature of some mental illnesses highlights the need for faith communities' commitment to ongoing involvement with (and outreach to) consumers and their families.
- Awareness that co-occurring disorders, such as substance use or a physical disability, may accompany and inhibit recovery from mental illnesses is helpful.

"Sharing my story has been one of the greatest ways to relieve stigma. A few months ago, I organized a walk across Wisconsin for awareness."
(Clergy/consumer)

Cultural competence

- A faith community's awareness of mental health consumers' backgrounds—including language and cultural understanding of mental health—in accommodating their needs is important to recovery.
- Using "people-first" language—saying "a person with mental health issues" or "a person with a mental illness," rather than "a mentally ill person"—is an important practice in a welcoming community.
- It is important to understand that traditional healing practices, in addition to or instead of contemporary mental health practices, may be important to some persons with mental illnesses.

"Many small, ethnic minority churches impacted more on me than a community support program, because of the cultural affinity."
(Faith community organizer)

Other factors

- Mutual aid: Individuals help themselves when they support others.
- Tradition: A sense of historical connection related to faith can be healing.

Factors That Hinder Recovery

Participants identified a number of factors, related to consumers, faith communities, and the broader community, that can impede recovery:

Discrimination and stigma. The existence of discrimination and stigma within faith communities contributes to the burden of silence and secrecy consumers carry about their mental illnesses. They may feel shame about their illnesses and fear being judged negatively by members of the faith community because of their illnesses. The perception by members of the faith community that mental health consumers are somehow "different" may further heighten stigma and discrimination.

"I attempted to talk with my priest about my bipolar disorder, but I got the notion that I wasn't to talk about this." (Consumer)

Lack of outreach to persons with mental illnesses

- Welcoming people with mental illnesses is not a priority for some faith communities.
- Some communities lack knowledge about outreach strategies and practices.

Authoritarian perspective and/or lack of openness in some faith-based organizations. The hierarchies of some faith communities discriminate against and stigmatize clergy with mental illnesses. Many clergy who suffer from mental health problems fear seeking care because their positions in their pulpits may be endangered.

"As pastor, I kept my mental illness secret from my congregation for two years. Carrying the burden of silence is most difficult. They tried to put me on involuntary disability, to kick me out of the ministry." (Clergy/consumer)

Historical schism between religion and the mental health community. For more than a century, organized religion and the health field have taken divergent—and sometimes antagonistic—paths in their approaches to mental health. Consequently, many religious leaders lack an understanding of mental health issues and the possibility for recovery, while many health and mental health providers lack an appreciation for the significant role that religion, spirituality, and the faith community may play in healing.

Spiritual crises or emergencies not often validated. For many persons experiencing psychosis, there is a fine line between spirituality and madness. These "spiritual crises" or "emergencies" often are not validated by mental health professionals.

"How a person comes to accept and understand these experiences (spiritual crises) may be a key to their recovery, including believing and calling up a higher power for help." (Consumer)

System-Level Issues That Impact Recovery

In discussion of contextual issues, dialogue participants identified many factors that affect relationships between mental health consumers and faith-based organizations. These factors center around institutions that train religious and mental health providers, social policy, partnerships among community organizations that address the needs of persons with mental illnesses, the role of the Federal government in helping faith- and community-based organizations provide social services, and the role of consumers, among others.

Education and training

- Seminary training typically does not address the relationship between issues of spirituality and mental health.
- Training programs for mental health professionals lack instruction on the values and role of faith, spirituality, and religion in healing mental illnesses, and on how to integrate traditional healing practices.
- Chaplains in State hospitals—and clergy in general—typically are not considered integral members of the healing process or of the mental health team.

"Many practitioners don't understand the role of spirituality." (Mental health provider)

Faith-based organizations and social policy

- Faith-based organizations can reach beyond the charity model and implement a model that focuses on recovery, with and by persons with mental illnesses.
- Faith-based organizations can serve as a bridge when they focus on mental health issues, including discrimination and stigma in housing, insurance parity, seclusion and restraint, the criminal justice system, and addictions.
- Faith communities that wish to influence social policy and bring about social justice must allocate resources to undertake this work.

Issues of church and state. Some faith communities and government agencies avoid working with each other to provide social services because of misperceptions about the legal relationship between church and state. Education is needed to clarify the appropriate relationship.

"The faith community needs to be helpful in trying to overcome the resistance of the public health community." (Consumer)

Consumer participation

- Consumer representation on faith-based organizations' advisory groups and governing boards contributes to relevance of the organizations' programs.
- Consumers can serve in faith-based organizations as change agents, role models, and contributing members.
- Hierarchies in faith-based organizations and/or religious leaders may create barriers to participation for members, potential members, and clergy with mental health issues.
- "Nothing about us without us." Consumer empowerment is fostered by the involvement of consumers in all aspects of their connection with their faith community. Education about and access to information or services that are relevant and culturally competent empower consumers to make informed decisions.

Linkages between faith and community organizations

- Clergy need to know when and where to refer a person with mental health issues, and also to know how to support that person in the congregation.
- Mental health providers need tools to help them incorporate spirituality into their repertoires of healing techniques.

Faith-based initiative policy

- Officials of public mental health programs may see faith-based approaches as an opportunity to cut costs and to undermine or supplant the work of experienced mental health professionals. Emphasis on delivery of high-quality mental health services is imperative.
- It is important to provide technical assistance systematically to small faith-based and community organizations that serve people with mental illnesses to enable those organizations to compete successfully for Federal resources.

- Funds should be directed where the need is greatest. Technical assistance can enhance faith-based organizations' capability to use funds responsibly and effectively, and to integrate their work with the health care delivery system.

Research to develop the evidence base. Research should be directed toward the contributions of chaplains and faith-based organizations in the treatment and recovery of individuals with mental illnesses, and toward the factors that impede outreach to consumers.

Community organizing

- To implement effective links between faith-based and community organizations and mental health providers and consumers, all relevant stakeholders must join at the planning table in a collaborative framework.
- Collaborations and partnerships need to set short- and long-term goals that are incrementally achievable and measurable.

"I help to build multi-ethnic, interfaith coalitions around quality of life. I'm a community organizer with a spiritual imperative."
(Clergy/community organizer)